Appendix 17
Request for Reimbursement for OBRA Level I Screening Form Instructions

Use these instructions to complete the "Request for Reimbursement for OBRA Level I Screening" form. Reimbursement requests are denied if the following information is not provided..

Provider Name
Enter the name of the facility providing the Level I screening.

Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the facility providing the Level I screening.

The following information must be provided for each Level I screening completed.

Applicant Last Name
Enter the last name of the applicant receiving a Level I screening.

Applicant First Name
Enter the first name of the applicant receiving a Level I screening.

Social Security Number
Enter the 9-digit Social Security number of the applicant receiving a Level I screening.

Screen Date
Enter the date (in MMDDYY format) that the Level I screening was given.

Admit (Y/N)
Indicate if the recipient was admitted to the facility with a "Y" for yes or "N" for no. A "Y" or "N" must be indicated.

Signature/Date
An authorized representative of the facility must sign and date the request form.

Send Completed Forms To:

EDS
6406 Bridge Road
Madison, WI 53784-0002